Chapter 3: Supporting and Serving Our Citizens

Building a system of supports, treatment and services for people with disabilities that makes it possible for them to live meaningful and satisfying lives in communities of their choice is a gradual process influenced by many considerations. Progress needs to occur on a number of fronts simultaneously, such as building infrastructure, developing community capacity and acquiring skills needed to apply best practice models that are shown to result in positive outcomes for people. The changing system must also continue to provide needed services to people without interruption during the change process and support them through the transition periods. The first step must be to develop community capacity. In order to accomplish this, there must be a reduction in the system reliance on institution/facility care. In addition, the philosophy of supporting and serving people must move to a person-centered support and treatment approach and real life outcome oriented system.

These steps will result in transitions from state-operated institutional services to community-based supports and services. The Division will ensure that clients who transition to the community will receive services that are equal to or better than those received in the institution. In addition, the types of supports and services currently offered in the community will become state-of-the-art practices that are ultimately supported through evidence-based and best practice models that are proven to be the best methods of response for people identified in the target population as well as referred through the uniform portal.

This chapter begins with a presentation of person-centered planning, as it applies to all populations. The second major section is the description of case management. Particular models of case management are included in the disability specific best practices. The final major sections are presentations of best practice for each disability group. A resource listing for the best practice areas for each of the four disability groups (adult mental health, child mental health, developmental disabilities and substance abuse) are included as appendix A.

Person-Centered Planning

At the heart of the reform efforts is person-centered planning. Person-centered planning is the life planning process that applies across all citizens who are supported and served. Person-centered planning is not a program. Person-centered planning is a life planning method (process) of determining ends (real life outcomes) for individuals and developing means to those ends (strategies).

Process

There are four key models of practice that are recognized as legitimate, person-centered planning methods: Essential Lifestyle Planning (ELP), McGill Action Planning System (MAPS), Personal Futures Planning (Futures) and Planning for Alternative Tomorrows (PATH). Wraparound is also

recognized as a person-centered planning process for families and children. A particular method is chosen based on an individual's life circumstances, situation and condition.

All of these methods have key similarities. They all involve a process of negotiation. All of the methods are dynamic; they occur on an "as needed" basis. Also, they all use a quality improvement process that involves continuously monitoring progress and using the resulting information and data to continuously improve the plan to assure the achievement of desired outcomes. In addition, any legitimate person-centered planning process contains certain core components. The person-centered planning process and person-centered plan must:

- Be driven and owned by the individual with the disability.
- Involve a sustained commitment to the life of the individual with the disability.
- Be strengths-based.
- Include both a proactive and reactive crisis contingency plans.
- Include reasonable assurances of health and safety.
- Contain strategies that reflect the most natural, durable and sustainable methods of achieving the outcomes.
- Be "real life" outcome oriented.

Real life outcomes

Real life outcomes are defined as related to life domains and are intended to reflect the most natural, durable and sustainable life of an individual – community inclusion. Examples include housing, career and vocational, educational, health, clinical, social, intimate relationships, friendships, spiritual, civic and economic dimensions. The number of life domains that need to be addressed at any point in time may vary, but as many as possible should be examined. In addition, strategies to address life domains should include consideration of how strategies can be integrated around the individual as well as how individual outcomes may be integrated with other outcomes (developing relationships and employment, as examples).

Strategies

Strategies are the methods that are intended to promote the achievement of the outcomes. Strategies are to be considered in the following order:

- **Personal resources:** Resources can be strengths such as concrete things that we have the ability and willingness to contribute or priceless attributes about ourselves or family that see us through to happier times. Other personal resources include financial resources possessed by the individual. This does not include driving people further into poverty.
- **Natural supports:** People most closely associated with the individual. This does not include "dumping" on natural supports.
- **Natural community resources:** People, places, social institutions and systems available to all people in the community. This does not include "dumping" on the community.

- **Specialty community resources:** People, places, social institutions and systems that are specifically intended and designed for accommodating and supporting people with disabilities. This includes other entitlements, designated resources and other legally oriented provisions (housing, school and vocational, as examples). This does not include inappropriate "cost shifting" in any direction.
- **Specialty supports and services:** Publicly sponsored provisions of support, service and treatment.

It is critical that the development of the person-centered plan does not become the outcome. The person-centered plan is the map that guides the individual and his/her natural supports, personal and community resources and publicly sponsored specialty supports, services and treatment to move towards his/her real life outcomes.

Case Management

Case management models are central to serving people with the most severe forms of mental illness, developmental disabilities and substance abuse and children with severe emotional disturbance. Individuals with less severe forms of mental illness, developmental disabilities and substance abuse and individuals actively recovering from mental illness and substance abuse require much less case management. In fact, many individuals with mental illness and/or substance abuse will require no case management at all. A hallmark of their recovery is that they truly become their own life managers. Case management models (e.g. assertive community treatment, intensive family intervention, community support program and varieties of wraparound) are designed to respond to the needs of people who have not benefited from the traditional service delivery system, i.e., categorical services. Categorical services are meant to respond to the needs of a category of people, not an individual's unique needs.

The case management function is key to the development and operation of participant-driven, outcome oriented, cost-effective human services system. With a central adherence to an advocacy perspective, case management is a service function delivered by providers that applies five dynamic and interrelated processes of assessment, planning, linking, coordinating and monitoring. These activities are all recipient specific and therefore require that the individual case manager have an ongoing relationship with the individual customer. Carrying out these five processes results in the preparation and implementation of a person-centered plan (PCP) through a person-centered planning process. Ultimately, the case management function is to assure that a person-centered planning process occurs for each customer and that the services/supports/treatments, formal and informal, specialty and non-specialty, are delivered/acquired in accordance with the plan.

There are several population-specific case management models of practice that are included within the models of best practice included in this chapter. Each varies in the manner in which the five processes are carried out and the corresponding skill set requirements. Variations in model selection depends on the nature and type of disability (mental illness, developmental disability, severe emotional disturbance and substance abuse) individual life circumstances, situations and conditions (life domain related) and individual history (past success with particular models).

Examples in variations of individual models include support coordination, clinical case management and intensive case management. These models include variations in types of professionals (e.g. substance abuse specialist, social workers and nurses), caseload size (staff-to-client ratios) and primary location of service (e.g. clinic or community). Examples in variations of comprehensive case management models nationally include assertive community treatment, intensive family intervention and community support program.

Case managers must have the skill sets necessary to respond to each individual's unique strengths and needs. This is best achieved by the fundamental competencies in the following categories.

Values related

- Believes that people are in command of their life and have priorities that are just as important as what professionals think.
- Believes that consumers are full citizens and deserve to be supported in the least restrictive environment.
- Believes that all children have the right to grow up in a family and in the community. (Some children may need brief out of home placements, but the case manager closely monitors the care and works toward transition back to their community.)
- Is culturally proficient and sensitive (i.e., speaks appropriate language and does not judge family culture).
- Adheres to the most efficient use of public resources.

Plan related

- Learns from consumers who is important to them in their lives as well as those who should be involved in the person-centered plan (e.g. significant others, family and caregivers members, friends, employer, social services worker, schoolteacher, probation officer, housing authority personnel, etc.).
- Helps the consumer configure those important people so that planning can begin.
- Using a person-centered planning process, develops a person-centered plan (PCP) with the consumer/family that identifies real life outcomes and utilizes the consumer, family/friend and community strengths as strategies.
- Assists consumers/family with looking across life domains to establish priorities in planning.
- Skilled at and takes responsibility for proactive and reactive crisis planning and safety planning.
- Knows the difference between needs and services.
- Utilizes services as strategies after all other alternatives that are more durable have been discussed. Doesn't jump to services to meet every need. Instead, can develop durable supports (e.g. a parent network that exchanges respite with one another or a social network where self esteem is built naturally such as church choir, bowling leagues, sewing clubs, community play houses, empowerment groups at the YMCA or YWCA, etc.), as opposed to a therapeutic intervention by a professional.
- Implements, coordinates and manages all aspects of the PCP.

Specialty supports and services related

- Requests for authorization and re-authorization by providers are coordinated with the case manager before formal requests go to the LME. (This involves ongoing coordination of the provider network at the micro level.)
- With the consumer/family, makes connections with other service providers in the network to be utilized as strategies to accomplish outcomes already identified in the PCP.
- Monitors the services provided by the network in terms of performance and progress toward outcomes identified in the PCP.
- Advocates for consumers to receive quality services from the network.
- Plans for, identifies and advocates for consumers to "step down" from more intensive formal services when appropriate.

Advocacy and community related

- Pursues the securing of all resource entitlements (e.g. Medicaid, food stamps) and other public and community resources – formal and informal, paid and unpaid.
- In addition to assisting non-Medicaid consumers in applying for Medicaid, helps each consumer through all levels of appeal.
- Has the skills to coordinate with physical health providers regarding medication, side effects, etc., whether these providers are furnishing these services through an integrated model in which the case manager participates, or is a member of the network furnishing these services in combination with other discrete services, such as therapy.
- Develops transition plans for changes in level of care.
- Is available after hours for first response crisis management. (Case managers within a network may establish an on-call system where they share crisis plans and rotate after hours coverage.)

Adult Mental Health – Best Practice

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant national consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

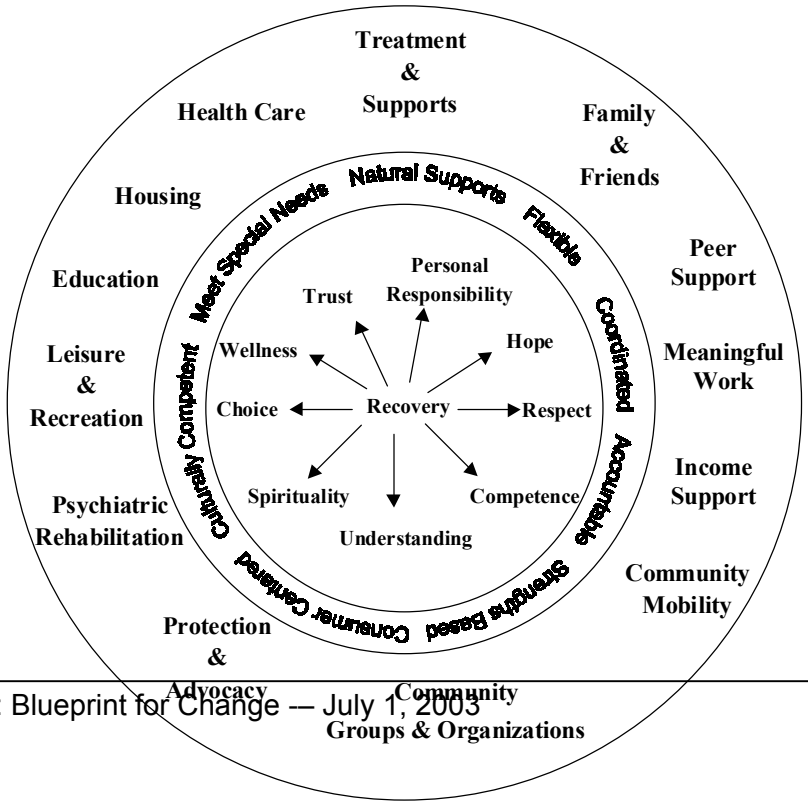
Foundation: Recovery Oriented Supports and Services

The concept of “recovery” is the foundation of all system efforts and best practice models. The concept of recovery has been traditionally associated with the alcohol and substance abuse recovery movement emphasizing self-help, mutual support and fellowship. Over the past several decades, recovery has emerged as a foundation on which best practice interventions for adults with serious mental illness are designed. For mental illness, the recovery approach can be compared somewhat to a person who undergoes a serious accident or illness and recovers from the acute event but retains some lingering residual effects or functional problems. There are five essential elements of recovery:

- Instillation of hope, a positive sense of self and a positive outlook for the future.
- Focus on strengths.
- Empowerment.
- Self-determination.
- Meaningful work and roles in life.

Recovery oriented supports and services facilitate a process whereby consumers define their strengths and goals and create meaningful lives and roles beyond that of “psychiatric patient.” Recovery oriented supports and services incorporate a tolerance for “set backs,” understand that the recovery process is not simple or linear and are provided in a care environment that is flexible enough to allow for the ups and downs of the illness. In a recovery framework, clinical decisions are evidence based, but always in the context of partnership and person-centered planning, which requires personal choice and a match of supports and services that respects individual needs and goals. Research has demonstrated that this approach results in positive treatment outcomes and high client satisfaction.

The illustration below shows the way in which the concept of recovery for adults with severe and persistent mental illness is essential to implementing reforms that are consistent with the State Plan vision and principles.



Best Practice Supports and Services

There is remarkable consensus around "best practice" supports and services for adults with severe and persistent mental illness. Those best practice services that have empirical evidence of efficacy are considered to be evidence-based practice. A national project supported by the Robert Wood Johnson Foundation has developed a series of evidence-based practice (EBP) tool kits. The EBP tool kits include sections for administrators, practitioners, consumers and families. They include training modules and they include evaluation instruments to assess fidelity to the model of practice. It is the intent of the Division that the services identified through the EBP tool kits are a priority. As soon as the tool kits are available to providers, the LMEs should utilize the tool kits in the development of these services, provide training based on the tool kits and utilize the evaluation tools through the LME's quality improvement responsibility to ensure fidelity to the model of service throughout the provider network.

Services for which EBP tool kits are available are:

- Medication management.
- Illness self-management.
- Integrated dual disorder treatment.
- Supported employment.
- Family psycho-education.
- Assertive community treatment.

Additional information regarding these six evidence based practices is available at *http://mentalhealthpractices.org* and other web sites listed in appendix A. While these evidence-based practice services should be given priority, they do not constitute the full array of best practice services. A list of best practice services by dimension is shown on the following pages. Essential elements of a best practice service are listed as well as characteristics of individuals who benefit most from this particular service. Services that have an EBP Tool Kit available are indicated with ***.

DIMENSION: CASE MANAGEMENT/ACT

Intensive Case Management

- **Essential Elements**

- Consumers are linked with all services, benefits and entitlements for which they qualify and that they choose to receive.
- Case manager helps with application process and advocates for entitlements, if consumer experiences a barrier to service or entitlement access, and monitors ongoing connection between consumer and entitlement/service.
- Case manager also partners with consumer to help connect with natural community supports and resources.
- Case manager to consumer ratio is maintained at approximately 1:25-30.
- Case management is provided within the context of a partnership relationship; the case manager provides support and problem-solving assistance, as needed.
- Case management occurs through community-based (rather than office based) contacts.
- 24/7 crisis response capacity for individuals being provided case management services.

- **Who Benefits**
  - Consumers with severe and persistent mental illness with multiple and/ or complex needs.

Assertive Community Treatment Teams***

- **Essential Elements**
  - Services provided by a team that is responsible for all client needs.
  - Team members share responsibility for all clients.
  - High team member to client ratio (roughly 8-10 clients per team member).
  - Services provided in clients' natural setting.
  - 24/7 coverage including as related to crisis response capacity for individuals being provided ACT services.
  - Shared caseloads among team members.
  - Flexible direct services.
  - Broad team skills and training (team has a psychiatrist, vocational specialist, nurse, SA specialist, etc.).
  - Client advisory mechanisms that provide oversight of the service.
- **Who Benefits**
  - Clients with high utilization:
    - Long periods in the hospital.
    - Frequent hospitalizations.
    - Repeated emergency room visits.
  - Clients with severe impairment in psychosocial functioning.
  - Homeless clients.
  - Criminal justice system.

DIMENSION: MENTAL HEALTH TREATMENT

Medication Management***

- **Essential Elements**
  - Rational step-wise, evidence-based approaches to symptom management.
  - Algorithms to approach the severe mental disorders.
- **Who Benefits**
  - Clients receive state-of-the-art medication management.
  - Clients are assured that treatment is based on a common knowledge base across the state.

Assessment

- **Essential Elements**
  - Telephone contact with clinician, and capacity for face-to-face 24/7, with contact for emergency care within 1 hour; urgent care w/in 48 hrs. and routine care within 7 days.
  - Should be done by a qualified professional receiving regular supervision, cross-trained in adult MH and SA across all age groups (i.e. young adult, adult, geriatric).
  - Must have access to psychiatrists, clinicians with expertise in MR/DD, and interpreters as needed, with explicit criteria for when these professionals are consulted.
  - Screening results in triage for determination of 1) emergent, urgent, or routine care; 2) appropriate and timely clinical referrals; 3) immediate medical evaluation; and 4) referral to social supports. Assessment verifies these determinations.
  - Assessment results in a diagnosis, case formulation, and initial treatment plan.
  - Assessment includes all clinically relevant information from the following areas: 1) chief complaint/ reason for referral; 2) history of present illness; 3) past MI/DD/SA history – with particular awareness for potential multiple disorders such as MI/SA; 4) mental status exam; 5) medical history; 6) substance abuse history; 7) family/marital/ relationship history; 8) psycho-social /developmental history; 9) involvement with criminal justice system; 10) occupational history; 11) educational history; 12) functional assessment, including ability to complete activities of daily living; 13) potential barriers to treatment; 14) strengths and resources; 15) socio-cultural diversity issues.
- **Who Benefits**
  - All clients seeking mental health services.
  - All individual receiving mental health services.

Illness Self Management ***

- **Essential Elements**
  - Psycho-education about illness including diagnosis and symptoms, effects of medication, stress-vulnerability model, effects of alcohol and drugs.
  - Allows avoidance and minimization of relapses through recognition of early warning signs of relapse, avoidance of alcohol and drugs, regular sleep and exercise.
  - Promotes interdependence between the individual and treatment and service providers.
- **Who Benefits**
  - Likely all clients.
  - Clients at risk of symptom exacerbation, re-hospitalization and relapse have been shown particularly to benefit.

Integrated Dual Disorder Treatment***

- **Essential Elements**
  - Concurrent treatment of mental illness and substance abuse by the same clinicians that assume responsibility for treating both disorders.
  - Key features include assertive outreach, stage-wise treatment, harm-reduction approach, counseling, motivational interventions and social support interventions.
  - Must be linked with comprehensive mental health services, culturally sensitive and focused on long-term goals and recovery.
- **Who Benefits**
  - Likely to benefit all individuals with co-occurring disorders.
  - Research and state reform efforts thus far have focused on individuals with serious mental illness and co-occurring substance use disorders.
  - About 50% of individuals with serious mental illness have a co-occurring substance use disorder. Dual disorder treatment is very important.

DIMENSION: CRISIS RESPONSE SYSTEM

Crisis Response System

- **Essential Elements**
  - May be provided by a mobile team that provides in-home or community-based crisis responses and resolution services.
  - Staffed by multidisciplinary treatment team.
  - An alternative or complementary model utilizes community crisis centers staffed with multi-disciplinary teams with observation or brief stay capability.
- **Who Benefits**
  - Individuals who experience a mental health crisis.

DIMENSION: REHABILITATION SERVICES

Rehabilitation Skill Teaching

- **Essential Elements**
  - Establishing a partnership between service provider and consumer.
  - Helping the consumer choose a role and setting in which s/he would like to live, learn or work.
  - Identifying the skills and resources needed to be successful.
  - Helping the consumer learn the skills needed to reach goals & linking the person with the support/resources needed for success.
  - Can be done individually or in groups.
  - Should occur over several months.

- **Who Benefits**
  - Individuals with severe and persistent mental illness with interest in employment, independent living and/or education.

Social Skills Training

- **Essential Elements**
  - Modeling, role playing, positive and corrective feedback, homework use social learning principles to teach social skills.
  - Multiple weekly sessions.
  - Individual and group formats.
  - Training lasts 3 months to over a year.
  - Training occurs in client's natural setting.
- **Who Benefits**
  - Individuals with schizophrenia who have poor social functioning.

DIMENSION: FAMILY AND COMMUNITY SUPPORT

Family Psycho-education ***

- **Essential Elements**
  - Multiple successful formats (single or multiple family sessions; locations include clinics, homes, family practices & other community settings; techniques include didactic, cognitive-behavioral, and systemic).
  - Longer, more thorough programs are more successful to a point.
  - Key element of psychoeducation is its focus: it must be on expectations and common goal setting, social and clinical needs, education needs, communication needs, family strengths and weaknesses, stress-reduction, problem-solving, coping, crisis plans, skills training and other support.
  - Oriented to future, not to past.
- **Who Benefits**
  - Clients in regular contact with relatives more than 4 hours per week.
  - Clients with time and resource intensive needs: emotional support, case management, financial assistance, advocacy, housing, etc.
  - Clients with little support outside of their family.
  - Benefits of family psychoeducation confirmed for a broad range of disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa and borderline personality disorder.

DIMENSION: PEER SUPPORT

Mutual Support Groups

- **Essential Elements**
  - Consumers share support, hope, skills and problem solving strategies with other consumers.
  - Voluntary and consumer run, without mental health professional leadership.
- **Who Benefits**
  - People with severe and persistent mental illness wishing to connect with others around recovery.
  - Research has shown that members of mutual support groups report increased hope and self-understanding, longer community tenure and increased social integration.

Consumer Providers

- **Essential Elements**
  - Consumers work in mental health settings (often as case managers), or have independent consumer run programs such as drop-in centers, employment programs or residential programs.
  - Consumer providers are paid employees, with more formalized infrastructure and interaction with consumer clients than in mutual support groups.
- **Who Benefits**
  - People with severe and persistent mental illness receiving or desiring community based services.
  - Consumers who wish to work as service providers.

DIMENSION: RESIDENTIAL STABILITY

Housing

- **Essential Elements**
  - Independence: 1) People choose their housing, including location and model; 2) leases or occupancy agreements clearly outline tenant rights and responsibilities; 3) the provision of services is distinct from the housing.
  - Affordability: Tenants should not have to pay more than 30% of income for housing costs.
  - Accessibility: Must meet a range of accessibility needs including being physically accessible, being accessible to needed services and close to public transportation.
  - A range of housing options should be available including permanent and transitional housing, building- specific and scattered-site housing and housing ranging from single occupancy to shared living space.
- **Who Benefits**
  - All individuals with severe and persistent mental illness who need safe and stable housing.

Jail Diversion

- **Essential Elements**
  - Case management.
  - Training to work with individuals with mental illness.
  - Ongoing collaboration with local criminal justice for diversion as early as possible.

- Aggressive identification of appropriate cases within the first 24-48 hours of detention.
- Data systems to track individuals through criminal justice and mental health systems.

- **Who Benefits**
  - Individuals who have been diverted from incarceration.
  - Individuals whose incarceration has been shortened.
  - The community in general.

DIMENSION: VOCATIONAL

Supported Employment***

- **Essential Elements**
  - Focus on and commitment to competitive work.
  - Rapid job search and placement.
  - De-emphasis on pre-vocational training & assessment.
  - Attention to client preferences.
  - Places all that desire employment, regardless of disability or skills.
  - Follow-along supports provided indefinitely.
  - Integration with case management and clinical services.
- **Who Benefits**
  - Supported employment is the most effective vocational rehabilitation approach for all persons with mental illness, regardless of work experience or disability.
  - Employers who hire persons with disabilities.
  - Persons with disabilities who receive employment.

Other Critical Areas

The following areas should also be provided particular attention as part of the supports and services for adults with severe and persistent mental illness:

- **Psychiatric inpatient:** Best practice models include alternatives to episodes of inpatient psychiatric care. Individuals may require periodic psychiatric hospitalizations. It is imperative that the process of discharge planning initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's discharge (housing, as a key example). Furthermore, the discharge itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon discharge. The person-centered plan crisis contingency component should address episodes of inpatient psychiatric care from admission to discharge.

- **Clubhouse models:** Clubhouse models such as psychosocial rehabilitation (PSR) and Fountain House provide an effective structure through which a number of best practices can be offered and integrated. For example, clubhouse models offer a structure for rehabilitation services and peer support. In planning the integrated system, the development of clubhouses as a structure to deliver best practice integrated services is strongly encouraged.

- **Integrated systems:** There are structures through which a number of the best practices can be offered and integrated. For example, as stated in the prior section, the clubhouse models (PSR and Fountain House models) offer a structure for rehabilitation services and peer support. Another example used in a number of states is the Community Support Program service definition that includes a number of these components in a single blended, active service performed by provider organizations. Planning the integrated system includes closely examining the various best practice models and applying said models into corresponding structures for delivery. This further advances the notion of integration between provider organizations as well as within particular support and service structures.

Child Mental Health – Best Practice

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Systems of Care

The State Plan requires that services to target populations reflect best practice. Accordingly, services for children and their families should be defined by outcomes that demonstrate (Surgeon General Report, 1999, President's New Freedom Commission, 2002) "achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; meet developmental milestones, function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (Hoagwood et al., 1996)". Further, because children are not little adults, their services must be planned and delivered in the context of their social environments of family, peer group and schools/work and their larger physical and cultural surroundings. This is particularly true for children with moderate and severe emotional disturbances - diagnosed mental health problems that substantially disrupt a child's ability to function socially, academically, and emotionally.

The State Plan requires that services be provided and developed within a family-centered and strengths-based orientation, promoting community-based comprehensive responses for children with complex and significant functional impairment due to mental, emotional and behavioral problems, and their families. The concept of family-centered and comprehensive care is the

foundation of all system efforts and best practice models for children and their families (President's New Freedom Commission, 2002).

This approach serves the whole family, not just the child with an emotional disturbance. It is based on flexibility, recognizing that parents and families have strengths for meeting their needs, know their needs best and should not be restricted to a pre-selected list of services. It emphasizes respect for and partnership with families and children in the planning, delivery and evaluation of services and stresses collaboration among the various agencies that serve children with the goal of enabling children to live with their families, achieve success in home, schools and community. (President's New Freedom Commission, 2002) This description of child mental health best practice is to provide clarification on these issues as they relate to children with moderate and severe emotional disturbances, and their families. Specifically, it will address:

- Elements of a comprehensive, family-centered orientation as it relates to support and service provision.
- Integration of effective mental health services for children with other agencies that serve them supported and held accountable within a system of best practice.
- Person-centered planning within a wraparound approach that addresses the ecological and developmental context of children's lives.
- Best practice services, interventions and supports that result in meaningful outcomes for children and their families.

Best Practices in Comprehensive Community-Based Support and Services

Achieving meaningful outcomes for children with mental health problems requires that services be delivered within a family-centered and comprehensive care framework. Services must be:

- **Family-centered:** A family-centered approach is embraced across disciplines and settings, recognizing the centrality of the family in the lives of their children. Family-centered services are guided by fully informed choices made by the family and focus on strengths and capabilities of these families. Family-centered care providers acknowledge that each family member influences the family as a whole. Family-centered service providers try to address all challenges that may influence children who need care, meaning that they work with other agencies to provide wrap-around care. Family-centered professionals look for the strengths of each family member and value parental knowledge and experience. (Beach Center on Disability, University of Kansas) http://www.beachcenter.org/frames.php3?id=55&category=Research

- **Wraparound**: Services and supports are planned and delivered in the context of full partnership with the family through wraparound approaches in child and family teams. Community agencies, private providers, family members and advocates then work together to support child and family teams and hold each other accountable for outcomes through local community collaboratives (Burchard, J.D., Bruns, E.J., & Burchard, S.N. (2002) "The Wraparound Approach," in B. Burns & K. Hoagwood (Eds.) *Community-Based Interventions for Children and Families*. Oxford: Oxford University Press).

- **Provided across agencies**: Children needing mental health services may be identified directly by their families; however, they are often identified through one of five distinct types of service sectors: schools, juvenile justice, child welfare, general health and mental health agencies. These agencies have different mandates to serve various groups and to provide somewhat varied levels of services. Many of these agencies arose historically for another purpose, only to recognize later that mental health problems cause, contribute to or are effects of the trouble being addressed (President's New Freedom Commission, 2002 Surgeon General's Report). A comprehensive community-based mental health service system must tackle the problem of service fragmentation. Fragmentation leads to and overuse of costly and largely ineffective out of home placements. Fragmentation must be replaced by creating a coordinated network of services and supports for these children and their families (President's New Freedom Commission, 2002).
- **Culturally responsive and community connected**: A key to the success of mental health programs is how well they use and are connected with established, accepted, credible community supports. The more this is the case, the less likely families view such help as threatening and as carrying stigma; this is particularly true for families who are members of racial and ethnic minority groups (Bentelspacher et al., 1994). Mental health programs attempting to serve diverse populations must incorporate an understanding of culture, traditions, beliefs, and culture-specific family interactions into their design (Dasen et al., 1988) and form working partnerships with communities in order to become successful (Kretzman & McKnight, 1993). Ultimately, the solution offered by professionals and the process of problem resolution or treatment should be consistent with, or at least tolerable to, the natural supportive environments that reflect clients' values and help-seeking behaviors (Lee, 1996).

- **Be outcomes accountable**: Evidence-based clinical interventions are integrated with family supports into a comprehensive plan of care that is individualized for each child and family and that change over time to ensure a goodness of fit. Clinical interventions must be held accountable by functional outcomes that measure a child's success for the child and family at home and school/work and in the community.

Family-Centered Wraparound Approaches as a Unifying Model

The Division requires a family approach to support children and their families. This approach recognizes the importance of the family system and the fact that the services and supports will have an impact on the entire family system. Therefore, the focus of the person-centered planning process is the child/family and recognizes that family members are integral to the development and implementation of the plan. The literature indicates wraparound as best practice for children with serious emotional disturbance and/or substance abuse and their families.

Wraparound is a team approach to children's mental health services that has evolved over the past 15 years through efforts to help families with the most challenging children function more effectively in the community. It was conceived as and is intended to be an alternative to institutionalization and as a response to growing concerns about the ineffectiveness of overly restrictive, categorical mental health and special education services for children with emotional and

behavioral disabilities. More specifically, it is a definable family-centered planning process that results in a unique set of community services and natural supports that are individualized for a child and family in the home, school and community environments to achieve a positive set of outcomes. Rather than being limited by the traditional placements usually offered (i.e., residential, special school, self-contained classroom), the wraparound approach allows providers and families to create individualized plans drawing from people and resources built across the various segments of systems. Supports are built into natural environments – nontraditional providers such as parent partners, student buddies, neighbors, faith-based organizations and volunteers are often part of a wraparound plan for a child and family. Wraparound approaches are universally recognized as identified as best practice in children's mental health (President's New Freedom Commission, 2002, Surgeon General's Report, 1999).

The service structures and practice principles listed below provide the framework necessary for implementation of wraparound – standards of care in services and supports that will help meet the family's needs and the structures within which services and supports are implemented. Operating simultaneously, they provide the primary active ingredients for outcomes-accountable, comprehensive care and treatment:

- Each child and family presents a unique combination of strengths and needs.
- Effective programs build on those strengths as they provide assistance to children and families, respecting culture and family preferences.
- Under wraparound every response will be different, because every child and family is different.
- Each plan of care should reflect and support those differences.
- Providers must be able to identify the functional strengths presented by children and families even when those children and families are experiencing serious problems in their lives. In addition, providers must be able to modify their service options in order to respond quickly and appropriately to the changing needs of each child and family. Furthermore, when children and families have complex needs and are open to several human service systems at the same time, providers must be able to work collaboratively with other individuals and agencies.
- Children and families should have one plan and one team, regardless of the complexity of their needs.

Service and Support Structures

Children with mental health needs and their families need flexible, community-based services that are managed and coordinated as an organized and collaborative service system:

- **Comprehensive plans of care through child and family teams:** Children and their families receive mental health services and supports through child and family teams (one family/one team/one plan), using person-centered and wraparound approaches. Comprehensive plans of care are authorized through the family's child and family team, regardless of where the child is residing.

- **Local decision-making and shared accountability**: Community collaboratives with broad representation across agencies/providers, families and community manage the overall wraparound process and establish the local vision and mission. Collaboratives provide shared leadership, support, responsibility and accountability for implementation of their community's service system. Participants are intricately involved in the development and implementation of their child and family teams and provider network and help ensure quality standards for care and outcomes.

- **Service array and access**: Children and their families have access to an accessible and comprehensive array of mental health/behavioral services, sufficient to ensure that they receive the treatment they need. A lead organization or a network of organizations delivering services is accountable to the community collaborative structure, which manages the implementation of the wraparound process. The array of services includes those provided in family's homes, in their children's schools and in other community locations as needed by the family. Treatment or resource coordinators assist the family, through their child and family team to access services and supports. Mental health services are adapted or created when they are needed but not available. The community collaborative structure reviews the plans.
- **Connection to natural/social supports:** The child and family team with assistance from the community collaborative identifies, promotes and appropriately utilizes natural supports available from the child and parents' own network of associates including friends and neighbors and from community organizations such as service and religious organizations.

- **Assessment:** Evidence based intervention begins with timely and accurate assessment of mental health needs using psychometrically valid and culturally instruments. Assessment instruments paint a picture of a child and family at a given moment in time. Whenever possible agencies doing assessment should try to get information from earlier assessments done by other agencies in order to get an accurate picture of the child.

Standards of Care

- **Collaboration with the child and family**: Respect for and active collaboration with the child and parents is the cornerstone to achieving meaningful outcomes. Families must be full and active partners in every level of the wraparound process. Parents and children are treated as partners in the assessment process, and the planning, delivery and evaluation of services and their preferences are taken seriously. Services include support and training for parents in meeting their child's mental health needs and support and training for children in self-management. Comprehensive plans of care identify parents' and children's need for training and support to participate as partners in the assessment process and in the planning, delivery and evaluation of services and provide that such training and support, including advance discussions and help with understanding written materials.

- **Functional outcomes**: Outcomes must be determined and measured for the system, for the program and for the individual child and family. Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety and permanence in home, school and community.

Services are designed and implemented to aid children to live with their families or in the most family-like setting, achieve success in school, avoid delinquency and become stable and productive adults. Implementation of a comprehensive plan of care stabilizes the child's condition and addresses any safety risks. Psychometrically valid and culturally sensitive assessment instruments should measure outcomes.

- **Collaboration with others**: The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized plan. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established plan of care is collaboratively implemented. Family-centered child and family teams plan and deliver services. Each child and family team includes the child and parents or caretaker, and any individual important in the child's life that is invited to participate by the child or parents. The team is lead by the parent/caretaker and a treatment/resource coordinator who is responsible to the team for planning, implementation and monitoring. The team includes any other persons needed to develop an effective plan, including, as appropriate, representatives from government agencies and the schools. The team (a) develops a common assessment of the child and family's strengths and needs, (b) develops a comprehensive plan of care, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.

- **Best practices**: Mental health services must be provided by competent individuals who are adequately trained and supervised, incorporate evidence-based interventions and are held accountable to provide services within best practices. There must be an unconditional commitment to serve children and their families. Comprehensive plans of care are continuously evaluated and modified to achieving outcomes, rather than ejecting the child or family from care or moving the child to multiple out of home placements.

- **Services tailored to the child and family**: Child and family teams must have flexible approaches and adequate and flexible funding to ensure that the unique strengths and needs of children and their families dictate the type, mix and intensity of services provided. Comprehensive plans of care reflect a balance of formal services and informal community and family supports. Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school and community. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking and what services they think are required to meet these goals.

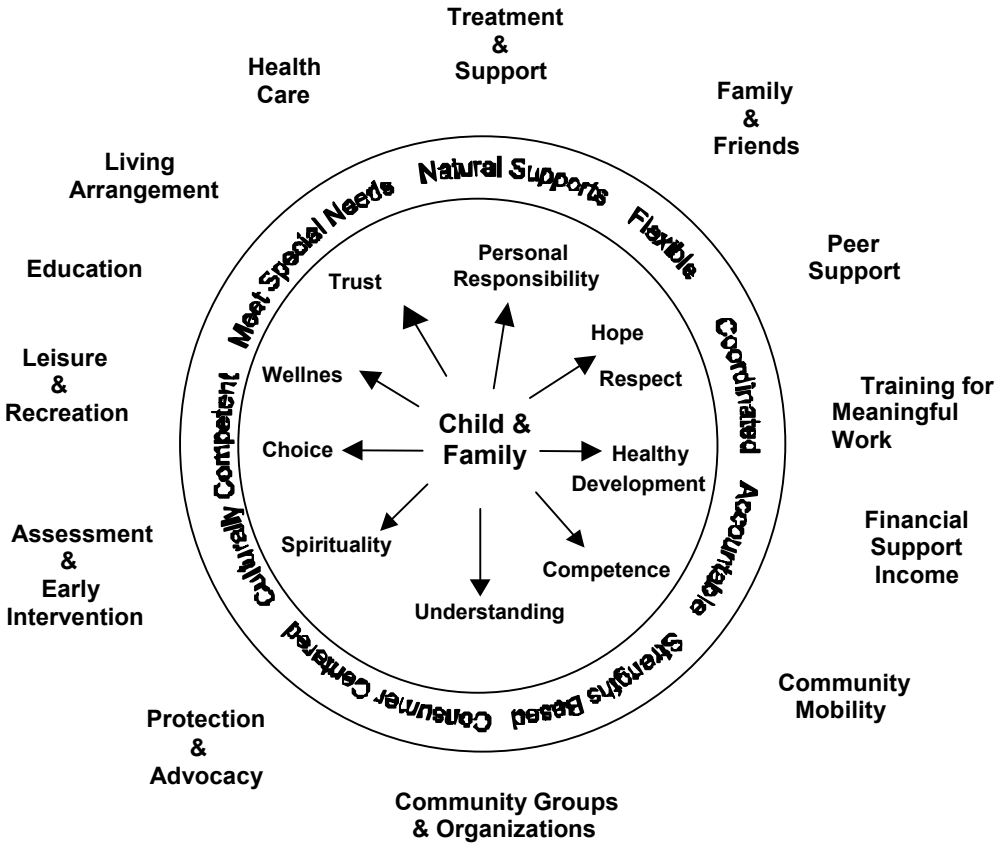
- **Stability**: Child and family teams strive to keep the child with his/her family, in his/her school and community. If a child is at risk of placement out of home, comprehensive plans of care identify steps to be taken to minimize or eliminate the risk. Child and family teams anticipate safety concerns or crises that might develop and include specific strategies and services that will be employed to address them. In responding to safety concerns or crises, all appropriate services will be used to help the child remain at home, minimize placement disruptions (if the child is already placed out of the home) and avoid the inappropriate use of law enforcement or the criminal justice system. Out of home placements for children with mental health needs are a last resort, used only for safety and treatment purposes that

relate directly to measurable outcomes, with concrete plans to bring them back to a stable/permanent home, their schools and community.

- **Transitions**: Comprehensive plans of care anticipate and appropriately plan for transitions in children's and their family's lives, including transitions out of wraparound services as well as transitions to new schools and transitions to adult services.

- **Respect for the child and family's unique cultural heritage**: The process must be culturally competent, building on the unique values, preferences and strengths of children and families and their communities. Mental health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

The illustration below shows the way in which the concept of wraparound for children with mental health/behavioral needs and their families is essential to implementing reforms that are consistent with the State Plan vision and principles.



Best Practice Supports and Services

There is remarkable consensus around best practice supports and services for children with mental health and behavioral problems and their families. Those best practice services that have empirical evidence of efficacy are considered to be evidence-based practice. A recent publication by Barbara Burns and Kimberly Hoagwood, *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders*, provides an overview and details. The Center for Mental Health Services, through annual reports on the National Evaluation to Congress and through their *Promising Practices for Systems of Care* monograph series, describes current and emerging research supporting best practices for children and their families. Additional best practice information is provided in the Surgeon General's Call to Action report on Child Mental Health and through reports of the President's New Freedom Commission. There is consensus across these publications that is reflected in this document.

It is the intent of the Division that the services identified through these documents are a priority. LMEs should utilize these materials for training and in the development of services, supports and integrated systems and utilize associated evaluation tools through the LMEs quality improvement responsibility to ensure fidelity to the model of service throughout the provider network.

The following breaks out the type of service and support array that should be available to children in an integrated service delivery system. The array is divided into three categories based on the role that the LME/mental health providers/Division of MH/DD/SAS has in this integrated system.

Things Mental Health Manages/Does	Things Mental Health Does in Collaboration with Others	Things Mental Health Promotes, Connects to and or Supports
Case management	School-based mental health services	Education, including early childhood
Intensive home-based family interventions	Integrated crisis response	Legal services
Community psychiatry	Positive behavioral intervention and supports (and school based wrap-around)	Protection and advocacy
Social skills/problem solving training	Integrated family support	Recreational activity
Respite care	Independent living supports	Family support and advocacy
Assessment for behavior health needs	Assessment for educational and family functioning	EPSDT and other early childhood health assessments
	Vocational counseling	Peer support and advocacy
	Multi-dimensional treatment foster care	Tutoring
	Early child hood screening	Nurse home visit/ wellness programs
	Treatment courts	Health services

	DSS – multiple response system	Respite cooperatives

A list of best practices for the services in which mental health carries the primary responsibility or directly collaborates is listed on the following pages. Essential elements of a best practice service are listed as well as characteristics of individuals who benefit most from this particular service.

DIMENSION: CASE MANAGEMENT

Case Management

- **Essential Elements**
  - Children and families are linked with all services, benefits and entitlements for which they qualify and that they choose to receive.
  - Case manager participates in and/or leads child and family team planning process with other child serving agencies and stakeholders to develop comprehensive, integrated, family-centered plan.
  - Case manager helps with application process and advocates for entitlements, if child or family experiences a barrier to service or entitlement access, and monitors ongoing connection between child/family and entitlement/service.
  - Case manager also partners with family/child to help connect with natural community supports and resources.
  - Case manager to child ratio is maintained at approximately 1: 12-15.
  - Case management is provided within the context of a partnership relationship; the case manager provides support and problem-solving assistance, as needed.
  - Case management occurs through community-based (rather than office based) contacts.
  - 24/7 crisis response capacity for individuals being provided case management services.
- **Who Benefits**
  - Children with serious emotional disturbances with multiple and/ or complex needs and their families/caregivers.

DIMENSION: MENTAL HEALTH TREATMENT

Intensive Home-Based Family Interventions

- **Essential Elements**
  - Child and family centered strength based mental health interventions emphasizing aggressively managed individualized treatment through person centered planning and delivered in the home.
  - Works with child in context of family to promote real life skills development.
  - Team includes Masters prepared clinician as therapist and case manager and paraprofessional(s) providing one-on-one implementation of the PCP.
  - Clinician specific interventions include: assessment, person centered planning, intensive case management, crisis planning, support, family education, individual and family counseling, life skills development, advocacy, monitoring of support and services purchased.

- 24/365 crisis intervention and management response directly provided by the home based case manager and Para-professional.
- Strengthens connections to informal community resources and natural supports rather than supplanting with Para/professional interventions.
- Interventions may include: all accepted and outcomes-based mental health approaches for children with serious emotional disturbances such as cognitive-behavioral, applied behavioral analysis, family systems, trauma therapy, and coordination with community psychiatry.
- For Substance involved youth, SA assessment and development of dynamic treatment plan.
- For Juvenile Justice involved youth and those with serious anti-social behavior, multi-systemic therapy may be used in the context of the home-based intervention.
- For multi-system involved youth the wraparound approach outlined in this document would apply.
- For children birth to 5 years old with attachment disorder appropriate attachment disorder treatment would be delivered.
- Includes a transition to independence process system (TIPS) to prepare youth and young adults to move into adult roles.

- **Who Benefits**
  - Youth with serious emotional disturbances but especially those with severely inappropriate behavior, with multi-system involvement, and at risk for out of home placement.
  - And for whom there is at least one family member/caregiver who is willing to participate in home based services.

Community Psychiatry

- **Essential Elements**
  - Psychiatrist works as part of multidisciplinary team in a community based program to meet the needs of child consumers.
  - Collaborates with public agencies, consumer groups and family organizations.
  - Understands and works with patients within their sociocultural context and strives for optimal enhancement of functioning and recovery.
  - Strong pubic education role and is source of expertise to colleagues, providers, community, consumers, and families.
  - Participates in development, implementation and support of comprehensive network of mental health services for children.
- **Who Benefits**
  - All children and families served by mental health system.

Assessment for Behavioral Health Needs

- **Essential Elements**
  - Strengths-based tool (for example BERS).
  - Integrated when possible with person/family centered planning process.
  - Looks across life domains and is based on life/family history.
  - Functional assessment approach.

- **Who Benefits**
  - All children seeking mental health services.
  - All children receiving mental health services.
  - Agencies learn how well clients are responding to treatment.

DIMENSION: MENTAL HEALTH INTERVETIONS DELIVERED IN COLLABORATION

Early Childhood Screening (with Public Health, Medical Community)

- **Essential Elements**
  - Children are screened early to prevent developmental and medical problems.
- **Who Benefits**
  - All children seeking mental health services.
  - All children receiving mental health services.

Positive Behavioral Intervention and Supports (with Schools)

- **Essential Elements**
  - Integrates school wide assessment of problem behaviors.
  - Use of behavioral science to institute practical functional based behavioral and academic interventions with all children.
  - While focused on reinforcing positive behavior in all children, PBIS directs more school-based supports from existing school personnel to those who need some additional intervention. Identifies the small number of children who need outside expertise including wraparound services.
  - Individualized support planning.
  - Team-based planning and problem solving.
  - Proactive, outcome driven perspectives.
- **Who Benefits**
  - All school aged children, but especially those with mild behavioral problems.
  - Children with more challenging behavior or at risk for problems.
  - School personnel get a systematic way to access formal mental health services for their most challenging students.

Treatment/Specialty Courts (with Court System)

- **Essential Elements**
  - Integrates family court, juvenile justice and child protective services hearings so decisions about same child are not made discretely from one another.
  - Case management that ensures that a single judge is responsible for all cases involving a given family and judge has access to all appropriate court and other records.
  - Mental health needs seen in context rather than as separate issue.
  - Judge able to remove barriers to cross-agency collaboration that facilitates data sharing, blended funding and cross training.

- Client monitoring is consistent as jurisdiction is maintained over case until resolution.

- **Who Benefits**
  - Children and families with multiple systems involvement.
  - Court personnel get better access to information about clients.
  - DSS, MH and justice personnel answer to one judge on each case.

Multi-dimensional Treatment foster Care (with DSS)

- **Essential Elements**
  - Foster families are recruited, trained, supervised and supported to provide youth with close supervision, fair and consistent limits, predictable consequences and a supportive relationship with an adult.
  - Youth participate in weekly therapy to assist in adjustment.
  - Main treatment effect is expected to occur in the MTFC. PCP/FCP outcome domains are closely monitored.
  - Youth participate in a structured daily behavior management program that outlines activities and expectations.
  - Foster parents have daily phone contact and weekly meetings with support provider/case manager.
  - Family therapy is provided for youth's biological or adoptive families with a focus on problem solving and communication skills, de-escalating family conflict, advocacy training and methods of structured supervision in the MTFC home.
- **Who Benefits**
  - Children and Families for whom intensive home based treatment is not an option at that point, especially those with chronic anti-social behavior, severe emotional disturbance and delinquency.

Multiple Response System (with DSS)

- **Essential Elements**
  - Approaches child protective services through community child protection strategies which apply family support and family centered service principles while not compromising child safety.
  - Allows for more than one type of response to initial reports of child maltreatment.
  - Focused on family centered and strength based assessment and planning process rather than incident-focuses investigative processes alone.
  - When child's safety is not in question, stabilization of family is emphasized to enable parents to better care for children.
  - Child and family team approach used to develop plan of care and service delivery.
- **Who Benefits**
  - Children and Families reported for child maltreatment/neglect.
  - Case managers able to emphasize family strengthening, service delivery and connection to resources.

Assessment for Educational and Family Functioning

- **Essential Elements**
  - Strengths-based.
  - Integrated when possible with person/family centered planning process and other assessment processes through child serving agencies.
  - Functional assessment approach.
- **Who Benefits**
  - All children seeking mental health services.
  - All children receiving mental health services.

DIMENSION: CRISIS RESPONSE SYSTEM

Integrated Crisis Response System

- **Essential Elements**
  - Crisis plans.
  - Crisis services and hospital diversion.
  - Crisis respite.
  - Community Policing Mental Health (Charlotte pilot program).
  - School-based crisis response.
- **Who Benefits**
  - Community Crisis personnel (MH, DSS, EMT, police, Fire, hospital, etc) are involved, trained and prepared to handle child mental health situations in context of system of care principles.
  - Individuals who experience a mental health crisis.

DIMENSION: REHABILITATION SERVICES

Vocational Counseling and Independent Living Supports

- **Essential Elements**
  - Begins with middle school aged child and continues though transition to independence.
  - Establishing a partnership between service provider and consumer.
  - Helping the consumer choose a role and setting in which s/he would like to live, learn or work.
  - Identifying the skills and resources needed to be successful.
  - Helping the consumer learn the skills needed to reach goals & linking the person with the support/resources needed for success.
  - Can be done individually or in groups.
  - Should occur over several months.
- **Who Benefits**

- Individuals with severe emotional disturbances with interest in employment, independent living, and/or education.

Social Skills Training

- **Essential Elements**
  - Is not a "stand alone" service, as it co-exists within the comprehensive case management models of practice (e.g. Intensive In-Home, MST and Community Support Team).
  - Training is based on a documented curriculum that is developed by the Child and Family Team and utilized as a strategy in the PCP.
  - Utilizes a curriculum, which is a task analysis, typically a social task analysis intended to teach a specific skill or set of skills such as good decision making, relationship between cause and effect, how to make friends and be a friend, how not to get kicked off the football team, etc.
  - Is individualized for each youth served.
  - Modeling, role playing, positive and corrective feedback, homework use social learning principles to teach social skills.
  - Involves multiple weekly sessions to implement the individualized curriculum and is evaluated regularly for achievement of the intended outcomes.
  - The individual responsible for implementing the curriculum participates in the PCP process.
  - Individual and group formats.
  - Training lasts 3 months to over a year as long as intended outcomes are being achieved.
  - Training occurs in client's natural setting.
- **Who Benefits**
  - Individuals with schizophrenia who have poor social functioning.

DIMENSION: FAMILY AND COMMUNITY SUPPORT

Integrated Family Support

- **Essential Elements**
  - Services are provided in the context of partnership with family and natural community supports and include things like:
    - Family to family support.
    - Health services.
    - Independent living support.
    - Respite care.
    - Intensive home based counseling.
    - Peer and family support groups.
    - Advocacy training and support.
    - Psycho-social education.
  - Services are integrated with DSS, Courts, DJJDP, Schools and other stakeholders where possible.

- Match parents with trained/experienced peers while also providing education/technical assistance and support in group setting.
- Key element of psychoeducation is its focus: must be on expectations and common goal setting, social and clinical needs, education needs, communication needs, family strengths and weaknesses, stress-reduction, problem-solving, coping, crisis plans, skills training, and other support.
- Oriented to future, not to past.

- **Who Benefits**
  - Children and families with time and resource intensive needs: emotional support, case management, financial assistance, advocacy, housing, etc.

Respite Care

- **Essential Elements**
  - Temporary care for children with disabilities.
  - Trained providers offer relief and much needed breaks for full-time caregivers.
  - May be provided in the home, or in a group setting such as a group home, childcare center or a residential center.
  - Care is in partnership with family that includes clear expectations and guidelines.
  - Respite care is not a substitute for appropriate social and community interaction or regular child care services.
  - Respite provider is trained to provide care including skills for emergencies, but need not be professional.
- **Who Benefits**
  - Children who are at risk for out-of-home placement.
  - Families who face the possibility of having to place a child in an out-of-home setting.

DIMENSION: PEER SUPPORT

Peer Support

- **Essential Elements**
  - Child Peer Consumers share support, hope, skills and problem solving strategies with other consumers.
  - Voluntary and consumer run, with guidance of consumer/family organizations.
- **Who Benefits**
  - Children connect with others around recovery and have opportunity to share their experiences and helping others.
  - Research has shown that members of mutual support groups report increased hope and self-understanding, longer community tenure, increased social integration.

Other Critical Areas

The following areas should also be provided particular attention as part of the supports and services for children with serious emotional disturbances or severe and persistent mental illness.

- **Psychiatric inpatient**: Best practice models include alternatives to episodes of inpatient psychiatric care. Individuals may require psychiatric hospitalizations. It is imperative that the process of discharge planning initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's discharge (continued family support and counseling, as a key example). Furthermore, the discharge itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon discharge. The person-centered plan crisis contingency component should address episodes of inpatient psychiatric care – from admission to discharge.

- **Brief out of home placements**: Best practice models such as wraparound services act as alternatives to treating children in residential settings. There are situations in which treatment while remaining in the home is not possible and may require placement in a residential treatment facility. Other community and home based models of treatment delivery should be explored first, guided by a "no-eject no-reject" philosophy. Out-of home placement should be planned to only be as long as needed to reach safety and treatment goals and should be delivered in the least restrictive setting. As with hospitalization, it is imperative that the process of planning for return to the home (or for some children a foster home/adoption placement situation) initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's return (continued family support and counseling, as a key example). Furthermore, the return itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon leaving the residential facility.

- **Monitoring of medications**: When medications are indicated as part of the treatment plan consumers and families should have access to quality assessment and diagnosis, appropriate algorithm use and consumer/family psycho-social and or medication education, so that families/consumers can advocate well with medical personnel regarding their medications.

Developmental Disabilities – Best Practice

We acknowledge that there are competing discussions in the developmental disabilities community regarding the identification of best practice models. Although the foundations of best practice are well recognized in the concepts of self-determination and person-centered planning, there continues to be debate around specific models of best practice across the spectrum of life domains, as well as the methodologies and data used to support these models. Elements of effectiveness have been identified and are beginning to be incorporated into emerging models. In light of this continuing discussion, specific models of best practice have yet to be identified within the State Plan. During SFY 03-04 the Division will work with stakeholders at the national, state and community levels to more clearly identify specific models and practices in all life domains.

State Plan 2003 has defined best practice in the interim as those supports and services experienced by the individual with developmental disabilities as being "responsive and effective." New methods will need to be developed to evaluate the effectiveness of the strategies we use to support individuals. Traditional quality assurance methods have often focused on the process rather than the outcome.

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Self-determination

Self-determination is not a program, it is a philosophy and set of principles to guide and constrain practice. Self-determination should be the vision of supporting the lives of all individuals with developmental disabilities. The consensus four principles of self-determination are as follows (Nerney, T., *The Poverty of Human Services: An Introduction*. The Self-Determination National Program Office of the Institute of Disability, University of New Hampshire. July, 1998; pp. 5-6).

- **Freedom to develop a personal life plan** – The work of those committed to persons with disabilities is simply to assist in operationalizing freedom for those who may need assistance in exercising this basic American right.

- **Authority to control a targeted sum of resources** – Systems committed to persons with disabilities have to first isolate the dollars available, no matter whether capitation strategies are utilized, and insist that the dollars be under the control of the individuals and freely chosen family and friends. This means the dollars are also free. They can be re-configured, priorities can be changed, and the dollars can follow the individual.

- **Support to obtain personal goals** – Those caring individuals who are committed to individuals with disabilities have to also be free to provide assistance both within and without existing systems to achieve the type and intensity of supports that an individual may desire.

- **Responsibility for contributing to one's community and using public dollars wisely** – Individuals with disabilities and those close to them have the ordinary obligation associated with freedom in America. These are obligations of citizenship and include the obligation to spend public dollars in ways that are life enhancing and cost-effective. This obligation includes engaging other social, business and religion organizations in ways that help redefine and build community for all of us.

Best Practice Supports and Services

While acknowledging that a system will always seek to organize itself around programs and activities, best practice for providing services and supports to persons who experience developmental disabilities is person/family-centered and focuses on the goals and outcomes identified by the person with the disability. In any field, best practices are those activities that are responsive and effective, particularly in the experience of the individual. This means that their use must be based on a track record of success and that their value must be clearly evident through research. As their use becomes standardized, other pockets of excellence may arise and be considered best practice. There should always be tension between the standard of care and emerging best practices.

There are a number of elements or features in the overlapping disciplines and fields involved in services and supports for persons who experience disabilities that serve to define a best practice. While not all-inclusive, the following elements/characteristics are apparent in the field of services and supports for people with disabilities:

- **Person/Family Centered**: responsive to the "customers" of the system.
- **Array of Options Exist**: choices exist among both paid and natural supports.
- **Informed Choice**: based on knowledge/experience of person/family.
- **Balance of Supports and Needs/Interests**: "no more and no less" than needed.
- **Periodic Evaluation**: to determine effectiveness and improve delivery of supports.
- **Objective**: free of conflicts of interest in the determination of supports and services.
- **Competent Staff**: trained and knowledgeable staff, with strong supportive values.
- **Aggressively Integrative/Inclusive**: in provision of supports, e.g. living arrangements, employment, volunteer, educational, leisure, health, etc.
- **Culturally Competent/Sensitive**: responsive to the values and traditions of those served.
- **Monitoring and Evaluation Practices**: exceed health and safety requirements and are concerned with the total life situation of the individual and/or family.
- **Flexible System**: accommodates and actively supports (challenges itself) best practice.

The State Plan requires that services to target populations reflect best practice. The State Plan also requires that services be provided and developed within a self-determination orientation. Services, in and of themselves, or any specific constellation of services, do not define best practice for people who experience developmental disabilities. Rather, services are merely strategies to assist the person in attaining the goals and outcomes he or she individually identifies as important and desirable within the span and continuum of an array of life domains.

For example within the developmental disabilities community, life domain groupings and names may vary. Regardless of the labels, domains focus around where people live, work, recreate, secure health care and secure educational/habilitatative services. Some examples of ways that the DD community may structure life domains to be utilized in a person-centered system include:

- Access to habilitation and education.
- Community connections.
- Health and wellness.
- Recreation and leisure.
- Meaningful work and roles in life.
- Safe and secure environments.

Within each of the domains, dimensions and quality of life enhancement techniques are required. (Source: Robert L. Schalock, "A Quest for Quality," *Quality Performance in Human Services*, Gardner and Nudler) Dimensions include:

- Emotional well being.
- Interpersonal relationships.
- Material well being.
- Personal development.
- Physical well being.
- Self-determination.
- Social Inclusion.

Each dimension needs to include exemplary enhancement techniques. Examples include increasing safety, allowing for spirituality, allowing for intimacy, allowing ownership, encouraging proper nutrition and promoting positive social roles.

Strategies are the methods that are intended to promote the achievement of the outcomes. Often strategies are gathered up and become programs. Programs are not best practice, but how we organize our resources. Strategies that reflect the highest standards of care presently available in the system may or may not be best practice. The goal of the system is to take pockets of excellence considered the best practice known at the time and raise these best practices to the standard of care.

Substance Abuse – Best Practice

This section is presented as a process initiating with the foundations of practice and building to the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Recovery

Recovery is a philosophical framework for substance abuse that recognizes and accepts chronic disability as part of the person's life-long experience. A recovery-oriented model presumes that individuals can learn to effectively manage their symptoms, maximize their level of functioning and go on to attain a life of meaning, productivity and satisfaction. For substance abuse, the recovery philosophy emphasis is on development of the individual's coping mechanisms and self-esteem primarily derived from learning, self-help, peer support and pursuit of valued life roles. The recovery concept is at the heart of effective substance abuse services and an integral foundation of the state system reform. The Division embraces a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and rebuilding a life despite or within limitations imposed by that condition.

The best practice for a recovery oriented system identifies and builds upon an individual's assets, strengths and areas of health and competence that supports a sense of achievement and mastery over his or her condition while regaining a meaningful, constructive sense of membership in the broader community. The recovery process is not simple or linear. It is a life long process of change and growth that is frequently marked by periods or episodes of relapse. Recovery is a multileveled, complex, developmental process of change at behavioral, cognitive, psychodynamic, systems and spiritual levels. As SAMHSA's Workgroup on Substance Abuse Self-Help Organizations states, "there are a variety of pathways to recovery and providers should have a menu of treatment and self-help group options available for use when selecting care in consultation with the consumer and other stakeholders."

The State Plan requires that services to target populations reflect best practice. Best practice for substance abuse services is built on the core philosophies of recovery and person-centeredness. These philosophies emphasize services that are client influenced and driven and produce real life outcomes. Additionally, community substance abuse services must be grounded in the framework of the National Treatment Plan developed by the Center for Substance Abuse Treatment (CSAT). Further, they must follow guidelines published by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the evidence-based requirements for effective substance abuse services published by the National Institute of Drug Abuse (NIDA).

The specific language of person-centered planning has not been traditionally part of the lexicon of substance abuse services; therefore, the description provided here is intended to build upon the description provided at the beginning of this chapter. However, person-centered planning and thinking has always been central to recovery. Recovery from addiction has always focused not

only on the symptoms of and treatment for the disease of addiction, but also on the individual's life that is to be restored. This restoration of an individual's physical mental and cognitive functioning, as well as the restoration of the individual's family, social network, community engagement and spiritual life has always been central to best practice in substance abuse services.

The Division has now adopted person-centered planning as a foundation for substance abuse best practice. The adoption of this philosophy will help formalize as part of the best practice system core beliefs, processes and outcomes that support an individual's recovery and empower the consumer to identify and reach their own real life outcomes. In addition, any best practice person-centered planning process contains certain core components. Motivational Enhancement Therapy is showing promise as an important strategy for all substance abuse target populations and empowers the consumer to identify their own issues and motivation for change.

Clinical Protocols

The information that follows does not address the specific clinical protocols for substance abuse practice for programs funded by the North Carolina Division of MH/DD/SA services. Those specific clinical protocols can be found in a companion series entitled *North Carolina Clinical Guidelines Series V.: Treatment of Substance Abuse Related Disorders,* September 2003. LMEs will be required to arrange for each American Society of Addiction Medicine (ASAM) level of services to be available within their network. LMEs will be expected to demonstrate a diligent attempt to design, develop and contract for substance abuse services that meet evidence based best practices for each of the substance abuse target populations. The North Carolina Modified ASAM Patient Placement Criteria is the framework for the levels of care and patient placement process adopted under the reform efforts for substance abuse services (see appendix D).

Principles of Effective Substance Abuse Service

Using The National Institute of Drug Abuse's (NIDA) core principles of best practice for effective substance abuse services as a guide, North Carolina has outlined the following guidelines for effective services in the LME networks:

No single treatment service is appropriate for all individuals.

North Carolina's public substance abuse treatment system must have every level of care within each community network of services. Appropriate matching of addiction severity to intensity of treatment services by utilization of NC Modified Patient Placement Criteria (see appendix D) will insure successful treatment outcomes. Treatment services should be delivered in the least restrictive setting and most clinically appropriate setting possible. The networks are responsible for insuring that a repertoire of services exists which will allow treatment response to be tailored to the recipient's unique needs and life situations insuring that service responsiveness is person centered not program centered.

Treatment needs to be readily available.

North Carolina's State Plan 2002: State Strategic Business Plan outlines access standards for the system and expectations of the local network services. Additionally, treatment services to each consumer must be seamless without waiting lists or gaps between services particularly when the consumer is shifted between levels of care or referred to different providers.

Effective treatment attends to the multiple needs of the individual, not just his or her alcohol and drug use.

North Carolina has endorsed the use of a statistically valid and reliable assessment tool that will conduct a multi-dimensional assessment, history and diagnosis of addiction. The assessment and treatment planning processes will include the significant collaterals in the consumer's life. LMEs are expected to develop complete continuums of care inclusive of a comprehensive array of supports such as housing and transportation, childcare, legal assistance, education and vocational assistance, medical and financial (Refer to the earlier segment on Integrated System of Recovery Oriented Services and Supports). Additionally, services and programs should be ethnically, culturally, socio-economically sensitive and gender specific. The staff will be skilled and competent.

An individual's treatment and recovery plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

North Carolina has adopted the principles of person-centered planning that speak to regular ongoing negotiation with the consumer, continuous monitoring and assessment and insuring that the plan is a dynamic in nature addressing the changing needs of the consumer, their family and their situation. For substance abuse treatment to be most effective and responsive to the changing needs of the recovery environment, relapse prevention must be addressed within every level of care.

Remaining in treatment an adequate period of time is critical for treatment effectiveness and successful recovery.

Effective treatment principles in North Carolina will include treatment plan goals being accomplished prior to discharge.

Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for addiction.

Substance abuse treatment plans for consumers in North Carolina will reflect individual and group counseling as well as other behavioral therapies.

Medications are an important element of treatment for many individuals, especially when combined with counseling and other behavioral therapies.

Treatment records will document that every recipient of substance abuse treatment services in North Carolina will have been evaluated for the use of appropriate medication concurrent with behavior assisted therapies.

Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated manner.

Effective treatment of co-occurring disorders in North Carolina will include evidence that screening, assessment, treatment planning and delivery of services include co-occurring disorders and where present; treatment services will be integrated in a coordinated and effective fashion.

Medical detoxification is only the first stage of addiction treatment and by itself, does little to change long-term alcohol and drug use.

Effective treatment for addiction is a process and not a singular event or service. Detoxification represents the initial beginning of the recovery process. It is crucial that LMEs, provider organizations, and clinicians employ extraordinary measures to insure that referrals for subsequent levels of care occur without a gap in time or waiting period for service delivery.

Individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

Outreach to effectively engage consumers are imperative, particularly for those who are involuntary admissions. The local TASC staff is to be involved in coordinating plans and services for those consumers who have involvement in the criminal justice system within North Carolina.

Possible alcohol and drug use during treatment must be monitored continuously and interventions timely for treatment to be effective and recovery to occur.

Programs and services will use bio-medical measures to empower the consumer to monitor progress in their recovery.

Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases, and provide counseling, and case management services to help clients modify or change behaviors that place themselves or others at risk of infection.

LME's and Providers will insure that all admissions will be provided assessment for all of the above listed contagious and infectious diseases and provide appropriate and effective counseling and community support services to assist consumers in modifying their unhealthy behaviors to minimize or eliminate risk factors.

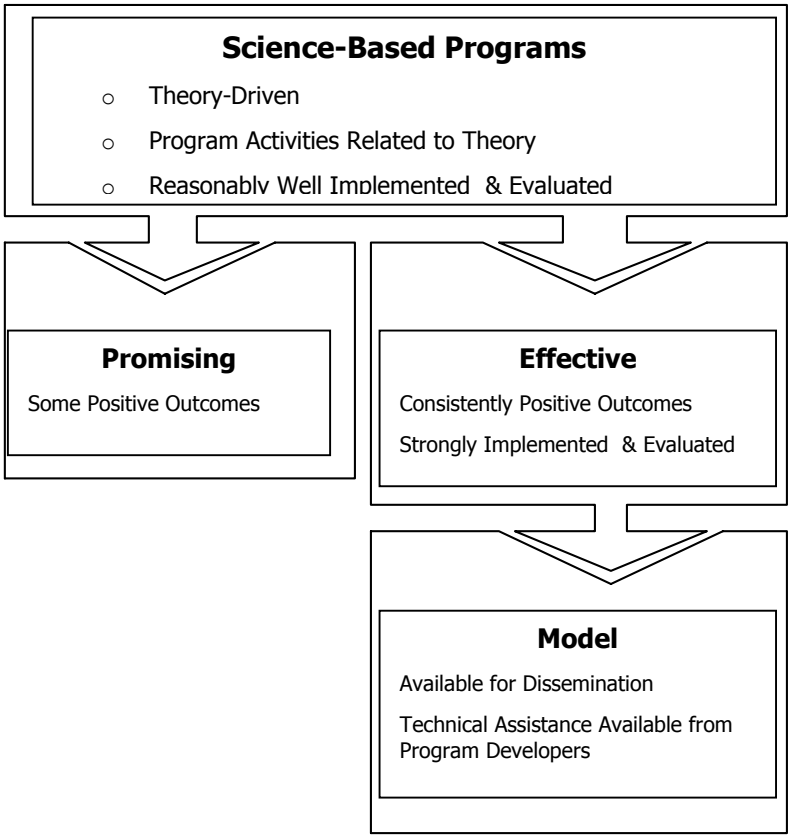
Early and ongoing recovery from alcohol and drug addiction can be a long-term process and frequently requires multiple episodes of treatment to be effective.

In North Carolina, relapse does not preclude readmission. Relapse patterns need to be evaluated and considered when utilizing the NC Patient Placement Criteria. Consumers who experience frequent relapse cycles need to be considered for placement to more intensive levels of care and are not to be excluded from admission to services.

What is a Best Practice?

In SAMHSA's Model Programs Manual, *Science-Based Prevention Programs and Principles*, 2002, best practice principles are outlined in the following manner. The strength of science and the scientific method is that it uses strictly defined, standardized procedures to determine how events are causally related. As science improves its methods, levels of certainty about the nature of cause-and-effect relationships increase and more is understood about the resources and effort to achieve specific changes in existing relationships. Using the scientific method more systematically to identify the knowledge also fosters recognition of the diversity of approaches involved in implementing programs and extracting data.

The reform of the substance abuse treatment system in North Carolina will employ those treatment elements, models, programs and therapies that have demonstrated evidence for promising and effective best practices within the substance abuse treatment research and literature.



Target Populations and Best Practice Supports and Services

This section provides information regarding the various target populations and best practices.

Target Population: Substance Abuse Prevention, Indicated and Selected

Substance abuse prevention best practice elements, models/programs/therapies is to be released in January 2004.

Target Population: Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs

- **Best Practice Elements**
  - Screening and assessment for co-existing disorders and communicable diseases.
  - Integrated treatment of HIV and substance abuse issues.
  - Inclusion of pharmacological and non-pharmacological treatment modalities to include individual, group, family therapy and support groups.
  - Provision or linkage to social services to include: case management, housing, home health care, respite care, transportation, legal and advocacy services.
  - Self help group attendance.
  - Inclusion of non-clinical activities to include: Alcoholics and Narcotics Anonymous meetings, spiritual development, stress management, and relaxation techniques.
  - Inclusion of the family and other collateral supports are essential to the effectiveness of the treatment effort.
- **Evidence-Based Models /Programs/Therapies**
  - Cognitive Behavioral Treatment (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training.
  - Medication Assisted Treatment (Methadone, LAAM, Buprenorphine).
  - Motivational Enhancement Therapy (MET) based on motivational psychology and designed to help the consumer mobilize personal resources to effect change.
  - Twelve-Step Facilitation Therapy based on the principles of Alcoholics Anonymous but an independent treatment designed to familiarize patients with the AA philosophy and to encourage participation.

Target Population: Substance abusing women with children and DSS-involved parents who are substance abusers

- **Best Practice Elements**
  - Use of state mandated assessment tool e.g. SUDDS IV. (Note for Work First Women target population, SUDDS IV is required.)
  - Offer gender-specific services that respond to women's needs regarding reproductive health, sexuality, relationships, and all forms of victimization. Services should be offered in a nonjudgmental manner and in a supportive environment.
  - Addresses links between addictive disorders and causal factors and consequences within the confines of the program including:
    - Sexual abuse.

        - Domestic violence.
        - Depression.
        - Suicidal ideation and attempt.
        - HIV risk factors and behaviors.
        - Family history of addictive behaviors, particularly parental substance abuse.
    - Insure primary, follow-up, and early intervention pediatric care for women's children including immunizations.
    - Provide therapeutic interventions for children in custody of women in treatment including such things as developmental screening.
    - Provide transportation services, including cab vouchers, bus tokens, and alternatives for women who live in communities where public transportation is cumbersome, or unreliable.
    - Offer childcare, baby-sitting, and therapeutic day care services for women accessing treatment and medical services.
    - Insure provision or referral of primary medical care for women receiving treatment services.
    - Conduct counseling services, including individual, group, and family therapy.
    - Offer vocational and educational services leading to training for meaningful employment.
    - Intensive community support/case management services a critical element in gender specific services.
    - Self help group attendance.
    - Provide age appropriate services that recognize the unique needs of adolescent substance-users who are pregnant.
    - Provide integrated trauma treatment with evidence-based model.
- **Evidence-Based Models/Programs/Therapies**
    - Trauma Recovery and Empowerment (TREM) This intervention, developed by Maxine Harris, covers 33 topics to be addressed in the process of recovery from trauma. Each topic is presented with a clinical rationale, a set of goals, a series of questions to be posed to the group and an experiential exercise.
    - Seeking Safety, developed by Lisa Najavits, Ph.D., is a highly structured intervention with evenly divided domains, which addresses a behavioral skill relevant to co-occurring disorders.
    - CASAWORKS, a model intervention designed for mothers receiving public assistance with substance abuse and addiction problems to help them become employed, sober and safe responsible parents.
- **Promising Models/Programs/Therapies**
    - Behavioral Marital Therapy engages family members to support the consumers' recovery efforts. Spouses are engaged in marital therapy, triggers for using are identified and efforts are made to improve communication and address areas of conflict.

Marital therapy has been shown to reduce treatment drop out and to improve marital relationships.

- Cognitive Behavioral Treatment (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training.
- Community Reinforcement Approach (CRA, CRA + Vouchers) Functional analysis, social and recreational counseling, employment counseling, drug refusal training, relaxation training, behavioral skills training, and reciprocal relationship counseling are the main components of CRA strategies. The addition of vouchers (contingency management) to the CRA model was done to reinforce abstinence.
- Dialectical Behavior Therapy (DBT) is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders.
- Motivational Enhancement Therapy (MET) based on motivational psychology and designed to help the consumer mobilize personal resources to effect change. Recommended as an engagement strategy for substance abusing women.
- The Relational Model developed by the Stone Center for Developmental Studies at Wellesley College the Self-In-Relation model offers a comprehensive, coordinated, family-centered or relational approach.

Target Population: Children and Adolescents with Primary Substance-Related Disorders

- **Best Practice Elements**
  - Treatment interventions tailored for adolescent engagement in ranges of developmental maturity. Adolescent treatment environments at every level of care within the continuum need to accommodate the differences in the adolescent developmental and attentional capacities.
  - Placement of adolescent consumer based upon the NC Modified ASAM criteria.
  - A complete continuum of care for adolescents is optimum or extremely close and coordinated linkages with a variety of levels of care. Movement of the adolescent between levels of care needs to occur as seamlessly as possible. Ideally, continuity of the counselor will be maintained throughout the treatment experience.
  - Family involvement offered within every level of care within the continuum is essential.
  - Clinical staff whose competencies demonstrate expertise in adolescent substance abuse treatment modalities.
  - A network of community resources and strategies for effectively integrating treatment for those adolescents with dually diagnosed conditions.
  - Individual and home base services indicated for juvenile justice involved children.
  - Group counseling is contraindicated for juvenile justice involved children.
- **Evidence-Based Models/ Therapies/Programs**

- Brief Strategic Family Therapy (BSFT) is a family-based, problem-focused substance abuse and behavior problem treatment and prevention intervention targeted toward children aged 6-17.
- Cannabis Youth Treatment Project (CYT) is targeted toward adolescent cannabis users between the ages of 12-18. It incorporates motivational enhancement therapy (MET) and cognitive behavioral therapy (CBT) as individually- and group-administered forms of treatment. It also includes Multidimensional Family Therapy and the Family Support Network and an Adolescent Community Reinforcement Approach.
- Cognitive Behavioral Therapy (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training designed for juvenile justice children.
- Multi-dimensional Family Therapy (MDFT) is a family-based, empirically supported form of treatment targeted toward adolescents, aged 11-18 with drug and behavior problems.
- Multi-systemic Therapy (MST) is an intensive, family-oriented, home-based treatment program targeted toward juvenile offenders aged 12-17 who exhibit problems of both substance abuse and chronic violence.

- **Promising Models/Programs/Therapies**
  - Managing Access to Juvenile Offender Resources and Services (MAJORS)
  - Motivational Enhancement Therapy (MET) based on motivational psychology and designed to help the consumer mobilize personal resources to effect change.

Target Population: Substance Abusing Adults Involved in the Criminal Justice System

- **Best Practice Elements**
  - Demonstrated partnerships between criminal justice (including courts, the judiciary, probation services, law enforcement, District Attorneys' offices, local BAR associations and Public Defenders' offices) and treatment systems. Utilizing the leverage of criminal justice requirements to engage and retain clients, with a therapeutic emphasis on motivating change in unwanted behavior. The partnership must be evidenced by local memoranda of agreement, cooperative agreements, routine meetings, collegial relationships, shared decision-making, etc.
  - The goal of reduced recidivism rates (probation violations, re-arrests, convictions, returns to prison) must be a shared goal of the criminal justice and treatment systems.
  - Screening, assessment and intake procedures must be in place to allow offender-clients to move quickly into treatment. Waiting lists for offender-clients are unacceptable. Programs must capitalize on the leverage provided by the justice system to employ this engagement strategy.
  - Treatment programs and services should operate according to detailed curricula that outline treatment activities, objectives & strategies. Activities should be intensive and behavioral in nature.

- Programs should target specific criminogenic needs (crime-producing behaviors). Eighty percent of any program's activities must target the behaviors that result in violations of the law. This may require specialized programs in some instances (e.g. sex offender treatment, anger management).
- The overall monitoring & structuring offender-client time is essential. Forty to 70 percent of an offender's time should be occupied. This may include treatment, community-based services, work, school, etc.
- Adequate treatment duration and intensity are critical for lasting change. This element varies by offender risk. Nine-twelve months of engagement in structured activities, including continuing care, are optimal.
- Clearly delineated program rules and sanctions for non-compliant behaviors must be discussed with and acknowledged by the offender-client. Any non-compliant behavior must be addressed from a strengths-based perspective with an eye towards both public safety and person-centered treatment plan goals. Use of behavioral contracting to clearly establish behavioral expectations.
- The appropriate use of rewards & punishments is vital. The ratio of rewards to punishments must be four to one, respectively. Actions within a program must target anti-social behaviors, by seeking to extinguish anti-social behaviors, while emphasizing pro-social behaviors, i.e. rewarding positive behaviors exponentially increases positive behavior, compared to the efforts of sanctioning of negative behaviors.
- Responsiveness, treatment and service matching are critical components of offender-specific behavioral healthcare. A variety of options along a continuum of care are critical to successful individual outcomes and public safety. Offenders, staff and programs must be matched based on risk to public safety, offender-client needs, learning styles, teaching styles, accessibility and personal preferences.
- A continuity of care must be maintained and supported during transitions (from community-to-prison & prison-to-community). That continuity includes a comprehensive, sequenced variety of interventions to address barriers faced by offender-clients, including education, housing, employment, treatment, self-help, and other essential support services.
- Service providers must "reach in" to the institution - drug treatment and other critical support service providers must engage the offender-client several months before release. Release planning must be coordinated between both the institution and community-based service providers.
- Urinalyses should be used judiciously and should be coordinated with justice system testing throughout program stays to identify needs for modifications to treatment plans or adjustments to levels of care.
- Training, modeling and reinforcement of pro-social behaviors is effective. Attempts to directly reduce negative behaviors are less effective. This element should be considered with regard to staff engagement capabilities that include staff-to-client therapeutic alliances with respect for justice system requirements.
- Engagement & retention strategies should also be employed with family and significant others to ensure a support structure for the offender-clients' success in the community. Family and significant others must be educated to be supportive. Mere orientation is inadequate.

- Programs must establish clearly defined completion criteria that are incorporated in the person-centered plan.
- Booster sessions, aftercare & continuing care must be provided. The application of ideas and positive, pro-social habits learned in treatment must be sustained. Sessions must reflect the offender-clients' person-centered plan, their progress in the level and modality of care in which they participated. It is inappropriate for an offender-client to "start-over" based on system difficulties relating to transitions.
- Performance evaluation capability is necessary for continued funding and to manage program improvement. Evaluation must include processes, outcomes and costs analysis to improve individual offender-client outcomes.
- More intensive treatment should be reserved for high-risk offender-clients. They respond better to intensive services, while low risk offender-clients do as well or better with minimal intervention. Residential treatment must be reserved for those offenders exhibiting the most severe addiction problems, and not used to temporarily warehouse "problem" offender-clients.
- Targeting of specific criminogenic needs treatment for specific types of crimes (e.g. sex offender, violence).

- **Evidence-Based Models/Programs/Therapies**
  - Cognitive Behavioral Therapy (CBT) – based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training. One type of CBT programs is Moral Reconation Therapy (MRT), which focuses on moral reasoning and development. MRT has been demonstrated to be effective in reducing recidivism in Washington state (MacKenzie, 1998).
  - Minnesota Model – includes multidisciplinary treatment team, a therapeutic community milieu, small group therapy, psycho-education, and aftercare. Although this model is traditionally a self-help approach with non-professional, recovering addicts as group leaders, it can be facilitated and delivered as a formal, curriculum-based treatment.
  - Social Learning – describes addiction as learned maladaptive behavior that can be treated by teaching and modeling pro-social behavior. This theory stresses modifying the individual's behavioral coping skills and cognitive processes to improve the ability to function in social environments (Parks et al., 1999).
  - Therapeutic Communities – the principle aim of a TC is global life-style change; including abstinence from AODs, elimination of antisocial behavior, enhanced education, constructive employment, and development of pro-social attitudes and values. All TCs include the following elements: community structure, hierarchy, and confrontation in order to rehabilitate clients (CSAT, 1995).
- **Promising Models/Programs/Therapies**
  - Treatment Accountability for Safer Communities (TASC) Services. TASC is a nationally recognized case management model for facilitating treatment for substance abusing offenders in the community. TASC case management provides structured linkages between the criminal justice and treatment systems through service coordination.

Target Population: Deaf and Hard of Hearing

- **Best Practice Elements**
  - Provide an identified clinician that is sign language fluent, culturally competent and familiar with evidenced-based practices to the deaf and hard of hearing population.
  - Treatment planning for the deaf individual with substance abuse issues needs to involve a member of the individual's family and/or sober support system.
  - Clinical services need to be designed to accommodate individual counseling sessions as well as peer-oriented feedback, and adequate recovering role models, preferably with sensitivity to issues of the deaf and hard of hearing culture and challenges.
  - Treatment activities need to accommodate a highly visible creative approach, not limited to reading and writing activities.
  - Optimum placement for deaf individuals experiencing substance abuse issues includes the following:
    - Adapted therapeutic approaches.
    - Staff fluent in American Sign Language (ASL).
    - Qualified interpreters.
    - Language accessible support groups and residential placements.
    - Utilize local deaf resources.
    - Recovering deaf role models.
    - Technology supports including TTY machines and necessary staff training to utilize the equipment.
    - Assisted listening devices.
    - Decoders and/or captioned video materials.
  - Use appropriate treatment model as indicated by assessment and NC Modified ASAM placement criteria.
- **Promising Practices/Models/Therapies/Programs**
  - Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing http://www.mncddeaf.org/

Target Population: High Management Adult Substance Abusers (includes sub-populations of co-occurring and homeless individuals)

- **High Management Best Practice Elements**
  - The high management substance abuse should be seen from a holistic, bio-psycho-social-spiritual perspective.
  - Self-help and peer supports easily accessible and integral to the recovery process.
  - Involvement of families and supportive collateral is crucial to effective treatment.

- Family education and support programs are essential for this population.
- Community Support Services play a key role in effective treatment.
- Multidisciplinary teams and approaches are necessary.

- **Co-occurring Disorders**
  - Integrated treatment of substance use and mental disorders need to be delivered by the same clinician who assumes responsibility for treating both disorders.
  - Medical education and group process are valuable elements of the treatment process.
  - Ongoing support, relapse management, and prevention are necessary strategies.
  - Understanding relapse and recovery are processes, not single events, and that relapse is not synonymous with failure is essential to successful treatment.
  - Provide multiple opportunities to learn about substance abuse treatment services so individuals can develop motivation to change.
- **Homeless Populations**
  - Conduct outreach to engage homeless people in services. Treat persons with respect and sensitivity. This is especially important in reaching persons who are disassociated from society and whom do not trust service providers.
  - Offer low-demand interventions and harm reduction strategies for those not initially willing or able to commit to sobriety. Model programs include sobering stations, safe housing for substance abusers, needle exchange programs and methadone programs.
  - Adopt a "no wrong door" policy through which individuals can access treatment from any location, any service provider, at any time.
  - Expect multiple detox and admission episodes with homeless individuals.
  - Supports to include self-help groups and community contacts.
  - Services should be provided in a convenient location according to a flexible, convenient schedule.
  - Ensure availability of a complete continuum of substance abuse treatment.
  - Provide a comprehensive array of services to address the multiple needs of homeless persons - i.e. housing, employment, counseling, etc. Integrate substance abuse treatment with mental health and primary health care. Provide case management to help homeless persons identify and access other services.
  - Provide adequate, supportive, clean and sober housing for persons recovering from addiction and affordable housing for persons exiting treatment.
  - Provide alternatives to jail for persons with substance use disorders charged with minor offenses. Provide opportunities for individuals to connect to services they need to rehabilitate.
  - Addressing physical health issues is paramount with this population.
  - Level of brain dysfunction is important to assess when intervening and designing services with this population.
- **Evidence-Based Models/Programs/Therapies**
  - Brief Therapies – e.g. solution focused, brief motivational counseling.

- Cognitive Behavioral Therapy (CBT) – based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques
- Motivational Enhancement Therapy (MET) – based on motivational psychology and designed to help the consumer mobilize personal resources to effect change.
- Twelve-Step Facilitation Therapy – based on the principles of Alcoholics Anonymous but an independent treatment designed to familiarize patients with the AA philosophy and to encourage participation).
- Therapeutic Communities (TC) – the principle aim of a TC is global life-style change; including abstinence from AODA, elimination of antisocial behavior, enhanced education, constructive employment, and development of pro-social attitudes and values. All TCs include the following elements: community structure, hierarchy, and confrontation in order to rehabilitate clients (CSAT, 1995).

- **Promising Models/Programs/Therapies**
  - The Healing Place, Louisville, Kentucky/Raleigh, North Carolina

Target Population: DWI Offenders

- **Best Practice Elements**
  - Utilize state modified ASAM patient placement criteria to match abuse/addiction issues with ADETS program or appropriate level of care.
  - Duration of participation is the strongest predictor for reduced recidivism with the DWI population.
  - Treatment should have specific measurable goals for the offender.
  - Treatment should provide for family involvement.
  - Psycho-education is an adjunct to treatment and does not substitute for treatment services.
  - Treatment that combines strategies, such as education in conjunction with therapy and aftercare are the most effective.
  - Mechanism for status reports back to the court to help enforce compliance with the court ordered assessment and treatment.
  - Medical backup to ensure safe detoxification and healthcare, if required.
  - Based on a personalized assessment process to accurately evaluate an individual's alcohol or other drug problem. The substance abuse assessment should be conducted separately from those utilized by the courts to decrease the likelihood of offenders distorting information for their potential benefit.
  - Provided over a sufficient period of time for meaningful behavior change to occur and be monitored. A minimum of twelve months may be required when follow-up or monitoring is included as part of the treatment package.

- Not be used as a substitute for other sanctions, especially license suspensions. Treatment programs are most effective in reducing recidivism when treatment is combined with sanctions, such as license suspensions and ignition interlock requirements.

- **Evidence-Based Models/Programs/Therapies**
  - Cognitive Behavioral Treatment (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques.
  - 12 Step Facilitation Therapy based on the principles of AA/NA/CA but an independent treatment designed to familiarize consumers with the self-help group's philosophy and to encourage participation.

Prevention

There is a growing body of new knowledge about effective prevention. Much of the work on prevention effectiveness comes out of extensive research on alcohol and substance abuse, but the efforts have usefulness among all disabilities. Prevention programs are reaching a new level of sophistication that includes evidence-based practices, outcome evaluations and cost/benefit considerations. In recent years, developing and delivering prevention services and programs has become a specialty in its own right. In the field of substance abuse, the prevention specialist develops a continuum of high quality prevention services consisting of:

- **Universal prevention** – targeted to populations not identified on the basis of individual risk, such as a school curriculum and healthy living skills. (See core functions.)
- **Selected prevention** – targeted to high-risk groups such as children of substance abusers.
- **Indicated prevention** – targeted to individuals with minimal but detectable signs foreshadowing substance abuse problems.

As an agency that purchases health care, the Division has an opportunity to effect change in the health status of the state by broadening the delivery system and incorporating prevention efforts alongside treatment, services and supports. Preventive interventions in physical health have been based on scientific evidence, and much has been learned about immunizations, smoking prevention and cessation, routinely covered preventive health screenings, and most recently, seat belt and helmet laws. Now there is evidence that risks also can be reduced for mental health problems, drug and alcohol abuse and physical illnesses in which onset is primarily related to behavior. By reducing risk factors and enhancing protective factors, many illnesses can be prevented or at least delayed.

As people become more informed about the effectiveness of risk reduction strategies for prevention of many mental health, developmental disability and substance abuse problems, they are more likely to demand these services. For example, individuals in recovery from alcoholism and drug addiction or those with some types of depressive disorders, may want preventive services for their children who are at high risk for similar disorders. Engaging individuals by offering

a menu of activities known to promote health and wellness can increase their knowledge and involvement in making decisions to seek out and apply prescribed interventions.

The science regarding risk and protection is large, changes rapidly and varies across disabilities. Prevention programs need to build their activities on a base of evidence sufficient to justify mounting preventive interventions.

Examples from CSAT and the national Mental Health Association of the best prospects for obtaining measurable outcomes are:

- "Prevention of initial onset of unipolar depression across the life span.
- Prevention of low birth weight and child maltreatment from birth to two years in children whose mothers are identified as being high risks.
- Prevention of alcohol or drug use by children who have an alcohol or drug abusing parent.
- Prevention of mental health problems in physically ill patients.
- Prevention of conduct disorders in young children.
- Prevention of fetal alcohol syndrome in subsequent pregnancies."

Patricia J. Mrazek, *Preventing Mental Health and Substance Abuse Problems in Managed Care Settings*.